Approved: March 6, 2008
Date

MINUTES OF THE SENATE HEALTH CARE STRATEGIES COMMITTEE

The meeting was called to order by Chairperson Susan Wagle at 1:30 P.M. on January 29, 2008 in Room 136-N of the Capitol.

Committee members absent: Senator David Haley- excused
Senator Mark Gilstrap- excused

Committee staff present: Ms. Emalene Correll, Kansas Legislative Research Department
Mrs. Terri Weber, Kansas Legislative Research Department
Ms. Nobuko Folmsbee, Revisor of Statutes Office
Mrs. Renae Jefferies, Revisor of Statutes Office
Ms. Margaret Cianciarulo, Committee Secretary

Conferees appearing before the Committee: Dr. Andrew Allison, Ph.D., Deputy Director,
Kansas Health Policy Authority
Dr. Marcia Nielsen, PhD, Executive Director,
Kansas Health Policy Authority

Other conferees in attendance: Please see attached guest list

Continued presentation re: Premium Assistance Plan

Upon calling the meeting to order, Chairperson Wagle referred the Committee to page 6 of the "Premium Assistance Fact Sheet "Kansas Healthy Choices" offered yesterday with Dr. Andrew Allison's testimony. The Chair then asked Dr. Allison to expand on the chart at the top of this page. A copy of the fact sheet is (Attachment 1) attached hereto and incorporated into the Minutes by reference. The Chair then asked for questions from the Committee which came from Senators Brungardt, Barnett, and Wagle ranging from:

- If you have children who qualify for HealthWave and the parents become eligible for this Plan, are you thinking about combining the two or what are you planning on doing?

- Is it possible for children to loose some of their prescription drug coverage if they are 100% on Health Wave?

- Clarification of the 75% concept and how does it work?

- Re: the 10-15% reduction in cost, does that include administrative costs for the Premium Assistance Program?

- Will we save money with this plan or will it be the same cost as Medicaid and can you give us an estimate of what you will save, even with administrative costs?

- Do you oversee the Health Wave Program?

- compare this approach to vouchers. Also regarding the Florida program, how is it working, how does it contrast with us and why you didn't choose this for Kansas?

- On seeking federal waivers to implement this program, is there a timeliness issue involved in this situation?

- What happens to your process with the federal government if something happens and it does not get funded in its first year. Does it affect your application and does it do anything long term?

Presentation on Insurance Clearing House and the Connector

As there were no further questions, the Chair thanked Dr. Allison and called upon Dr. Marcia Nielsen, PhD, Executive director, Kansas Health Policy, who offered visuals focusing on the health insurance Connector

which was something the Senate Health Care Strategies Committee discussed at length last year. She stated they would like to provide an update and the kinds of analysis that the KHPA did in collaboration with The Kansas Health Foundation. She then went on to provide background information, the 2006 study on the Massachusetts Connector, the 2007 health insurance modeling of a Connector, and described three of the five coverage models considered by the Board, In summary, she stated, the Board ultimately recommended the "Updated Sequential Model' to promote a three-pronged approach to expanding access:

1. Targeted and aggressive outreach to Kansas children already eligible for Medicaid/Health Wave,

2. Expanded premium assistance for very low income Kansas childless adults; and

3. A Voluntary Connector/Clearinghouse, combined with small group market reforms.

A copy of her testimony and attachment is (Attachment 2) attached hereto and incorporated into the Minutes by reference.

Chairperson Wagle then asked for questions from the Committee. Senator Barnett asked three questions of Dr. Nielsen:

1. Regarding Section 125 on the "Updated Sequential Option," we had a lot of commentary about what Missouri did. Tell us about your involvement in Missouri's plan with the Kansas plan and is this something that is doable?

2. Combining soul proprietors in small group markets, what holes do we step in when we try to do that?

3. Regarding reinsurance, where are we and how soon can we get there with the Insurance Department?

Adjournment

As it was going on to Senate session time, the Chair thanked Dr. Nielsen and the Committee. The meeting was adjourned. The time was 2:30 p.m.

The next meeting is scheduled for February 5, 2008.

SENATE PUBLIC HEALTH AND WELFARE COMMITTEE

GUEST LIST

DATE: Tuesday, January 29, 08

NAME	REPRESENTING
Katie Gribarich	Kearney & Associates
Amy Campbell	KMHC
Mary Ellen Conlee	Via Christi Health System
Jessica Concannon	KMS intern
Terry Slaughter	KMS
Gabrielle Hackaby	Sen. Dennis Pyle
Marci Nielsen	KHPA
Cynthia Smith	SCL Health System
Tim Shamm	self
Isaac Ferguson	Kansas Chamber of Commerce
Mike Huffles	PHS
Peggy Galvin	BCBS KC
Matthew Goddard	Heartland Community Bankers Assoc.
Fred Lucky	KAN. Hosp Assn
JOHN C. BOTTENBERG	CMFHP
Tony Wellever	KAMU
Todd Fleischer	Ks. Optometric Assoc.
Tracy Russell	KHPA
Christiane Swartz	KHPA

Please pass on

$5 in att.

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SENATE PUBLIC HEALTH AND WELFARE COMMITTEE

GUEST LIST

DATE: 1-29 Tuesday 2008

NAME	REPRESENTING
Shelly Litz	KHPA
Reagan Assimanio	KHPA
Sandra Braden	Gates, Braden, Barber
Jamie Jack	Federico Consulting
Jason Williams	Wellshear Gov. Relations

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SENATE PUBLIC HEALTH AND WELFARE COMMITTEE

GUEST LIST

DATE: 1/29/08

NAME	REPRESENTING
Pat Eaker	KS Comm on Disability Concerns
Mary Pearson	KSCDC
Denise Kelly	SRS
Shane Nicholas	Blue Cross Blue Shield KS
Bob Williams	KS. Assoc. Osteopathic Medicine

Pg 2

Service	State Employee Health Plan Coverage	KHC Coverage Level (for newly eligible parents above 37% of poverty)	HealthWave XIX Coverage Level
• Medical, surgical, anesthesia, diagnostic, therapeutic, and preventative services. • These services may be provided at clinics, rural health clinics, federally qualified health clinics or Indian health centers.	Yes	Ear and eye exams are required to be covered at 75% of this service level. All other services at 100%	100%
Inpatient and outpatient hospital services.	Yes	100%	100%
Laboratory services	Yes	100%	100%
Diagnostic and therapeutic radiology	Yes	100%	100%
Emergency room services	Yes	100%	100%
Mental health services, including inpatient and outpatient services, for all nervous or mental illness conditions (other than a biologically based illness).	Yes	75%	100%*
Prescription drugs, including injectable prescription drugs and intravenous drug treatments	Yes	75% Health plans are encouraged to promote the use of generic drugs; e.g., through tiered cost-sharing.	100%
Other Title XIX state plan services	Varies	Vendor's choice	100%
Other State Employee Health Benefits	100%	Vendor's choice	Varies
Services provided by neither the Title XIX state plan or the State Employee Health Benefit Plan	No	Vendor's choice	No

*Those eligible for Medicaid Title XIX under current rules will continue to participate in the Prepaid Ambulatory and Inpatient Health Plans.

How does the purchase of private insurance through Kansas Healthy Choices help *control state health care spending* for the poverty level population?

Neither publicly-financed health care programs, nor the private marketplace, have held costs in check in the United States. Insurance, in and of itself, cannot lower the underlying costs of care. By any reasonable standard, the private marketplace for health care is weakly competitive at best, and plagued with market failures and limitations that are endemic to the nature of medical care itself. It is difficult to come up with a market for goods and services in greater need of the support of public intervention than exists in health care markets, which would likely render most retired, and virtually all disabled and poor Americans, medically destitute were it not for the presence of government intervention through Medicare and Medicaid. KHPA proposes a number of systemic health reforms designed to encourage greater efficiency and lower costs by strengthening and expanding private markets, rather than replacing or eliminating them. The 21-point health care proposals address the source of health care costs in their emphasis on prevention, costly conditions such as obesity, and

gr increases access to care, although not to the level of more expensive private coverage. Families' a to c... also requires an adequate number of providers willing to participate in available health plans. KHC will provide access to networks of private, public, and safety net providers at the lowest potential cost to taxpayers by relying on the negotiating strength of procured plans, and by ensuring that provider reimbursement remains in line with expected rates for publicly-supported care. Even with KHC coverage, KHPA remains concerned about the availability of primary care medical homes, dentists, nurses, and other health care providers in Kansas.

How will Kansas Healthy Choices improve *health outcomes* for Kansas families?

KHC expands access to Kansas parents living in poverty, and is designed to provide care to all family members through a single private health plan of their choosing. Research suggests that better health outcomes are associated with a "medical home" – meaning that all members of a family receive services through a primary care provider who helps coordinate needed health care and preventive services. Having all family members insured as part of the same health insurance plan also helps coordinate care and helps to provide access to a "medical home."

How will Kansas Healthy Choices enhance support for safety net providers?

KHPA agrees with the need for a strong safety net, but disagrees with a strategy that depends solely on publicly-financed or publicly-employed providers. The principles of the safety net – subsidized care provided on the basis of need – are precisely the same principles that underlie publicly-financed insurance coverage, except that publicly-financed insurance opens up access to public dollars to all providers, including the much larger base of private providers, rather than restricting those dollars to the safety-net alone. KHC health plans will be required by Federal rules to contract with safety net providers, strengthening the financing base for these critical providers with Federal and state dollars.

How does Kansas Healthy Choices *differ from a Medicaid expansion*?

KHC's design is intended to mimic private coverage through an explicit linkage with the state employee health plan, with benefits similar to that provided by most large employers. Families rising out of poverty and leaving premium assistance will find that their individual or employer-based coverage looks much more like premium assistance than Medicaid or HealthWave. With the implementation of Kansas Healthy Choices, KHPA is proposing to provide about 20,000 current and 24,500 newly-eligible parents and their children with access to a market-oriented model, with Medicaid protections for children and existing eligibles. Where possible, families will enroll in employer-sponsored plans. Others will select private health plans that offer coverage explicitly tied to levels of coverage in the state employee health plan, with benefits that best fit their families' needs. Unlike Medicaid plans, the state-procured plans may offer different benefit coverage options for the expansion population of parents above 37% of poverty. Due to differences in the benefit package, the cost of KHC coverage for newly covered parents is expected to be significantly less expensive than a straight Medicaid expansion (projected costs are 10-15% lower than Medicaid on a per-member-per-month basis).

How will benefits be different than those provided through Title XIX Medicaid?

Benefits for newly eligible parents above 37% of poverty will differ from Medicaid. The following chart provides a list of optional and required services for new eligibles and those currently eligible for HealthWave Title XIX. Overall, procured health plans must offer a plan that is actuarially equivalent to the State Employee Health Plan.

Coordinating health & health care for a thriving Kansas

KHPA™

KANSAS HEALTH POLICY AUTHORITY

Testimony on:
Health Insurance Connector

presented to:
Senate Health Care Strategies Committee

by:
Marcia Nielsen, Ph.D. Kansas Health Policy Authority

January 29, 2008

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Kansas Health Policy Authority

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Topeka, KS 66612
Phone: 785-296-3270

Senate Health Care Strategies
Committee
Date: January 29, 2008
Attachment 2

Testimony to the Senate Health Care Strategies Committee
January 29, 2008

Health Insurance Connector
Marcia J. Nielsen, PhD, MPH, Executive Director Kansas Health Policy Authority

Good afternoon Madam Chair. I am Marcia Nielsen, Executive Director of the Kansas Health Policy Authority (KHPA). I would like to thank the Senate Health Care Strategies Committee for an opportunity to discuss our examination analysis of a health insurance connector to assist Kansans in accessing affordable health insurance. Four Kansas foundations: United Methodist Health Ministry Fund, Sunflower Foundation, REACH Healthcare Foundation, and the Health Care Foundation of Greater Kansas City generously financed the economic modeling of five different health insurance reform approaches. Three of those reform approaches integrated connector functions to accomplish various goals and I will discuss those today.

Background: Policymakers have long struggled with the issues faced by small employers trying to purchase affordable health insurance. Recent attention has focused upon the Commonwealth Health Insurance Connector established in Massachusetts, as a means to facilitate access to affordable health insurance among small employers and provide universal coverage to all citizens in Massachusetts. In an effort to assist states in understanding the development of a Connector structure, the State Coverage Initiatives Program issued a document entitled *Health Insurance Connectors & Exchanges: A Primer for State Officials* in September, 2007. That document delineates the various functions that different models of Connectors might provide including: creating a health insurance "clearinghouse", standardizing administrative functions, facilitating the aggregation of premium payments (employer and individual), providing human resource capacity, applying subsidy payments toward the cost of premiums, assisting consumers in selecting health plan choice, and informing consumers. The Primer cautions that states carefully delineate the functions they are seeking when considering adoption of a connector design.

2006 Study on the Massachusetts Connector: The 2006 Kansas Legislature, as outlined in proviso, directed the Kansas Health Policy Authority (KHPA) to prepare a report about the Massachusetts Commonwealth Health Insurance Connector Program. The proviso specified that the KHPA "…study the Massachusetts commonwealth health insurance connector program and provide a report….on the feasibility of implementing a similar plan in Kansas." On February 1, 2007 the KHPA presented to the Kansas Legislature its findings on the Massachusetts Connector. Results of that analysis indicated that due to multiple differences among Massachusetts and Kansas, a Health Insurance Connector faces many challenges if implemented in Kansas. Massachusetts was in a favorable position to implement a connector-type insurance model due to tight regulation of the small group and non-group health insurance markets, a reinsurance pool for both the small group and individual market, and the State's large program that makes supplemental payments for uncompensated care (over $600 million prior to the Connector). Kansas, on the other hand, faces challenges with implementing a Massachusetts-like Connector due to very limited Medicaid coverage of adults, a much more modest program of supplemental payments to providers for uncompensated care, and far fewer federal dollars dedicated to uncompensated care.

2007 Health Insurance Modeling of a Connector: In 2007, the Kansas Legislature requested in SB 11 that the KHPA analyze health insurance reforms and develop recommendations for the 2008 session. An independent economic analysis was conducted by SchrammRaleigh Health Strategy during the fall of 2007, which provided the KHPA Board and Staff information on multiple methods of health insurance reform for Kansas. Health insurance reform options were identified by SchrammRaleigh based on Kansas's existing health care marketplace and state-specific characteristics on the uninsured population. Reforms across the participation spectrum (voluntary to mandatory) as well as the access mechanism (public to private) were all considered by

the KHPA Board. SchrammRaleigh consultants provided a series of presentations to the KHPA Board in p. meetings through the summer and fall of 2007.

I will describe three of the five coverage models considered by the Board – those that contained a connector type function -- in more detail below. However, for background information it is helpful to note that the "baseline" modeling that was used by SchrammRaleigh to compare each of the new insurance models assumed implementation of the premium assistance program as authorized by SB11. In addition, a "reference" model assumed a straight Medicaid expansion for children and adults up to 250% of the federal poverty level (FPL).

Model 2: "Affordable Coverage Option – Voluntary Market Reform": This model involved voluntary individual and small group market reform with the merging of the two markets. Community rating and guaranteed issuance were included to ensure uniform coverage access, the use of Section 125 tax benefits was required, and subsidized reinsurance was included to control adverse risk selection. An insurance clearinghouse was created for this combined market to provide a review and approval of insurance products and assistance to employers in accessing Section 125 tax benefits.

After full implementation (as compared to the Baseline Model), the Affordable Coverage option would cover an additional 50,000 individuals through coverage offered by small employers and purchased individually by sole proprietors. *All of the 50,000 individuals would have previously been uninsured.* Insurance costs for the Affordable Coverage Option would be borne by self-paid expenditures at $134 million and the State at $93 million. The federal government and large and small employers would see decreases in their health expenditures as a result of implementing the Affordable Coverage option of $24 million and $6 million, respectively.

Model 3: "Universal Coverage Option – Mandatory Health Insurance": This model provided a mandatory health insurance reform through individual and employer mandates and most closely resembled the Massachusetts plan. This option included required access to Section 125 tax benefits and subsidized reinsurance to control adverse risk selection. A connector-like infrastructure would be established to maintain the insurance coverage mandates, assist employers accessing Section 125 tax benefits, set pay-or-play standards, establish affordability and minimum coverage standards and an exemption policy, and apply subsidies.

After full implementation (as compared to the Baseline Model), the Universal Coverage Option would cover an additional 247,000 previously uninsured individuals, and 66,000 individuals previously insured in the individual market would shift to large and small employer-sponsored coverage. Small employer coverage would increase 99,000, large employer coverage would increase 164,000, Medicaid coverage would increase 46,000, and Premium Assistance coverage would increase 4,000. The Universal Coverage Option would effectively eliminate the uninsured in Kansas. Insurance costs for the Universal Coverage Option would be borne primarily by large and small employers, which would experience an increase of $608 million, with the State experiencing an increase of $167 million in health care expenditures. Self-paid expenditures and the federal government would see a decrease in expenditures if the Universal Coverage Option were implemented of $217 million and $61 million, respectively.

Model 5: "Updated Sequential Option": This model is comprised of three parts with specific policy approaches designed to reduce the rate of uninsurance among specific target populations; low-income children, low-income child-less adults, and employees working for small businesses. The policy options targeted for small businesses creates a voluntary health insurance clearinghouse which would assist very small employers to access health insurance, provide human resource capacity, facilitate use of Section 125 tax benefits by small employers, combine sole proprietors and small group markets, and utilize reinsurance to spread risk.

After full implementation (as compared to the Baseline), the Updated Sequential Option would cover an

additional 12,000 uninsured sole proprietors and employees of very small businesses. Compared to Baseli... the Updated Sequential Option would increase the individual market by 12,000 previously uninsured lives while the small employer and large employer market would stay relatively the same. Through the three other provisions of the Updated Sequential Model, coverage will also be extended to an additional 20,000 children (Medicaid), 39,000 low-income childless adults (SB 11 expansion of Premium Assistance program), and 15,000 young adults (new products targeting this population). The Updated Sequential Option will decrease the rate of uninsured in Kansas by 33% or by a total of 86,000 individuals while having minimal impact on the small- and large-employer health insurance markets. Insurance costs for the Updated Sequential Option would be borne by a mix of individual, State and Federal government. Employers would experience a $1 million decrease in health insurance costs, individuals a $10 million increase, the State a $71 million increase and the Federal government a $65 million increase. When compared to the previous two models (Model 2 and Model 3), the Updated Sequential Option still provides a significant decrease in the number of uninsured Kansans, yet will have the least impact on the private markets and the smallest increase in government and self expenditures for health insurance costs.

Summary: The insurance models described here provided the Board with an opportunity to have a deliberative public dialog about the most pragmatic and politically feasible strategies to expand access to affordable health insurance in our state. The Board ultimately recommended the "Updated Sequential Model" to promote a three-pronged approach to expanding access: (1) Targeted and aggressive outreach to Kansas children already eligible for Medicaid/HealthWave; (2) Expanded premium assistance for very low income Kansas childless adults; and (3) a Voluntary Connector/Clearinghouse, combined with small group market reforms. We encourage legislators and stakeholders to review the SchrammRaleigh report, "Kansas: Pricing the Roadmap to Health Insurance Reform Options", which was generously funded by four Kansas foundations: United Methodist Health Ministry Fund, Sunflower Foundation, REACH Healthcare Foundation, and the Health Care Foundation of Greater Kansas City. The full report can be found at:
http://www.healthfund.org/pdf/11012007fdn_report_khpa.pdf

Regarding the ScrammRaleigh report, as recently described in a recent article by former State Representative Tim Carmody in KCB Magazine:

> *For several years, most polls and surveys have shown that the issue of how to pay for health care is a high priority for the public. Yet, there is no consensus on how to address the issue. The schramm-raleigh study not only provides support for the actual legislative proposal, but also goes beyond it in providing it in an understandable format, the raw data upon which policy must be made. In other words, if you have a preconceived opinion on the solution, check out the study to see how your opinion squares with the facts.*
>
> *Perhaps the most interesting thing to consider is the context in any given issue, position, or solution is framed. For example, one person's "single payer system" is another's "socialized medicine". One person's "business mandate" is another person's "tax". One person's "full access to health care" is another person's "Canada". The study allows one to consider the economic and, to some extent, sociological consequences of choices without a lot of preconceived labeling. Labeling is the choice of the reader. Understanding and informed policymaking are opportunities awaiting the legislature.*

Definitions

Massachusetts Health Insurance Connector: The Connector is a structure designed by policymakers in Massachusetts to facilitate the purchase of affordable, high-quality health insurance by small businesses and individuals without access to employer-sponsored health insurance. The Connector is an independent, quasi-governmental entity designed to facilitate the purchase of health care insurance at affordable prices by eligible individuals and small groups. The Connector is a self-governing, separate legal entity from the Commonwealth and is governed by a 10-member board consisting of private and public representatives.

Section 125 Plans: Section 125 of the Internal Revenue Code provides companies a vehicle to allow their employees to pay for certain qualified benefits on a pre-tax basis, which allow employers to establish tax-preferred benefit programs that can make health insurance more affordable. Section 125 qualified plans allow employees to pay for certain qualified expenses before taxes are deducted from their paycheck, thus maximizing an employee's take-home pay and minimizing an employer's payroll-related taxes. These qualified expenses can include health insurance premiums and certain out-of-pocket health care expenses.

Reinsurance: Reinsurance is a mechanism for distributing risk across a larger pool of people and can lower insurance costs for some consumers, protect the solvency of insurers, and stabilize the small group insurance market. By assuming unpredictable high cost risks, reinsurance can stabilize the volatility of premiums and allow purchasers to more accurately forecast costs.

Adverse Risk Selection: Adverse Risk Selection occurs when individuals voluntarily purchase health insurance because they expect to use health care services (i.e., they are sick and unhealthy) causing the groups to have high medical claims thus raising premium costs for all members, including those who are healthy.

Pay-or-Play Mandates: Pay-or-Play Mandates are essentially employer health insurance mandates. Employers are required to provide insurance for their employees or otherwise pay a fine or tax if an employer decides not to comply.

schramm raleigh HEALTH STRATEGY

Updated Sequential (Includes Board input)

Major Differentiator

- 3 Part Reform – Outreach for Children, Expand SB11, and Voluntary Connector/Exchange

STRUCTURE

1. Targeted Outreach - Children: Aggressive marketing to enroll already eligible kids
   - Medicaid/SCHIP up to 200%
2. Expand SB 11 to include Childless Adults up to 100% FPL
3. Voluntary Connector - Small Market Reforms:
   - Voluntary Health Insurance Clearinghouse
   - Targeted Market Reform
     - ✓ Development of "micro-markets": Combine Sole Prop's with Groups (1-10 ee's) and provide subsidized reinsurance to new Very Small Group (VSG) mkt
     - ✓ Targeted Products for Young Adults (ages 19-24)
     - ✓ Pilot projects
   - Assist Small group in Section 125

POLICY DECISIONS

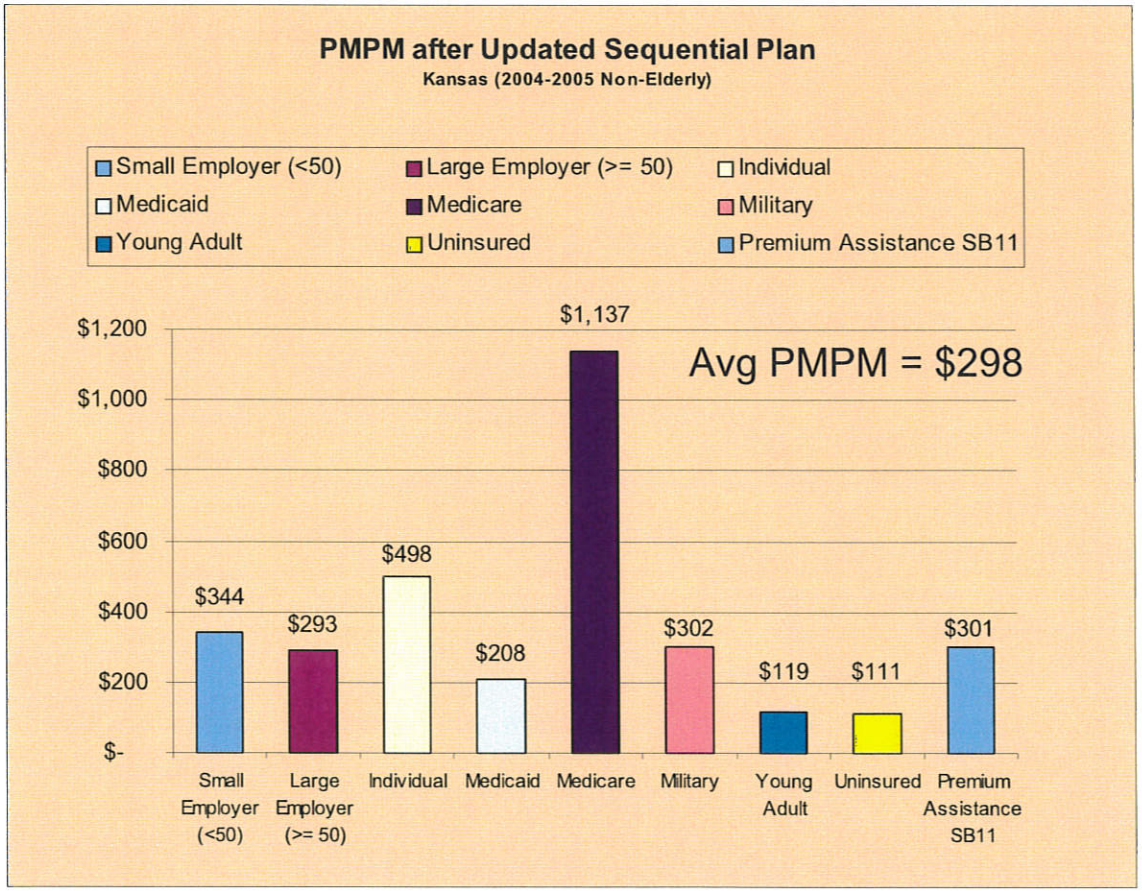
1. Program Design – Market Driven Reform:
   - Choose Phased Vehicle(s) for Targeted Outreach
   - Expand SB11 to 100%
   - Change Kansas Insurance Laws
   - Establish VSG Reinsurance Program
   - Determine VSG Reinsurance Funding
   - Choose Vehicle(s) for Educating all Small Employers about Section 125

ISSUES

- Outreach Effectiveness
- Combined Market – Selection v. Level-Playing Field
- State Match/Vehicle

DRAFT - SUBJECT TO CHANGE
ILLUSTRATIVE ONLY

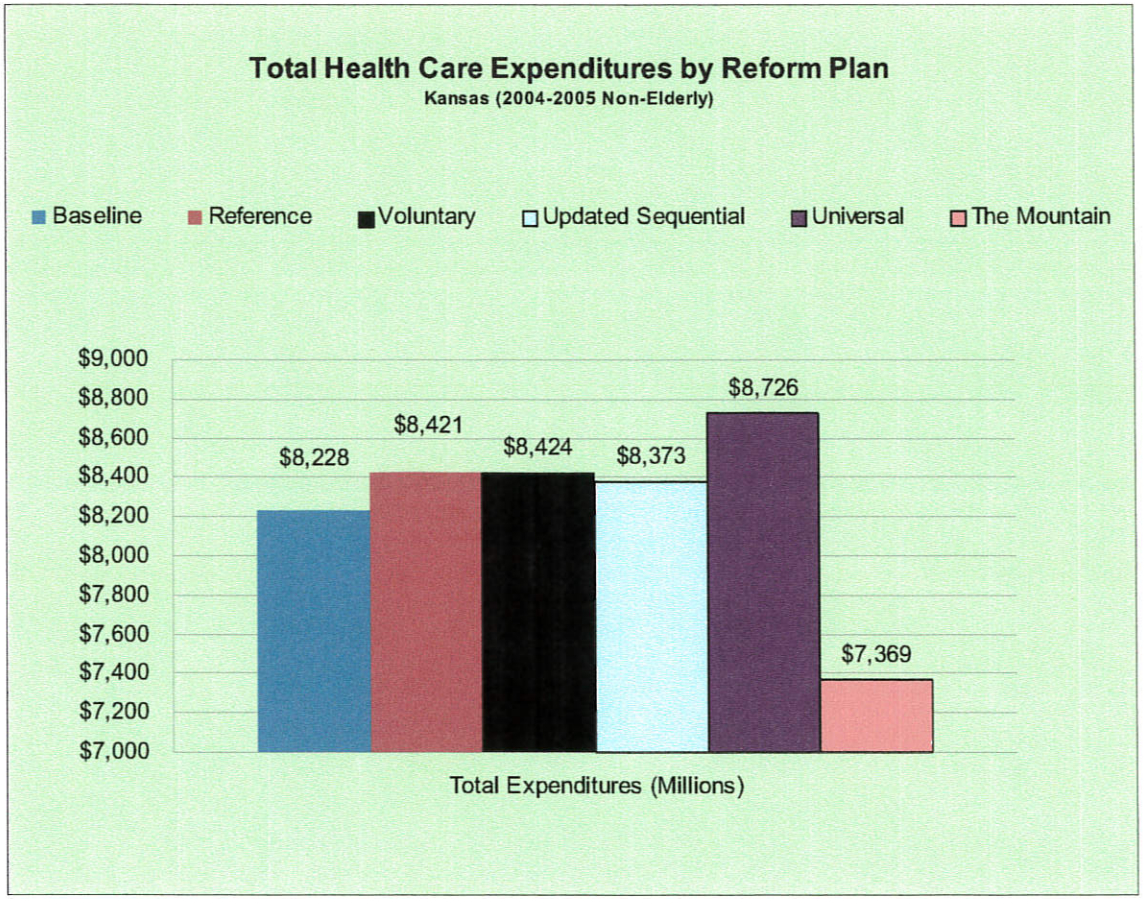
Updated Sequential Plan



Source: srHS HCRTC Model

DRAFT - SUBJECT TO CHANGE
ILLUSTRATIVE ONLY

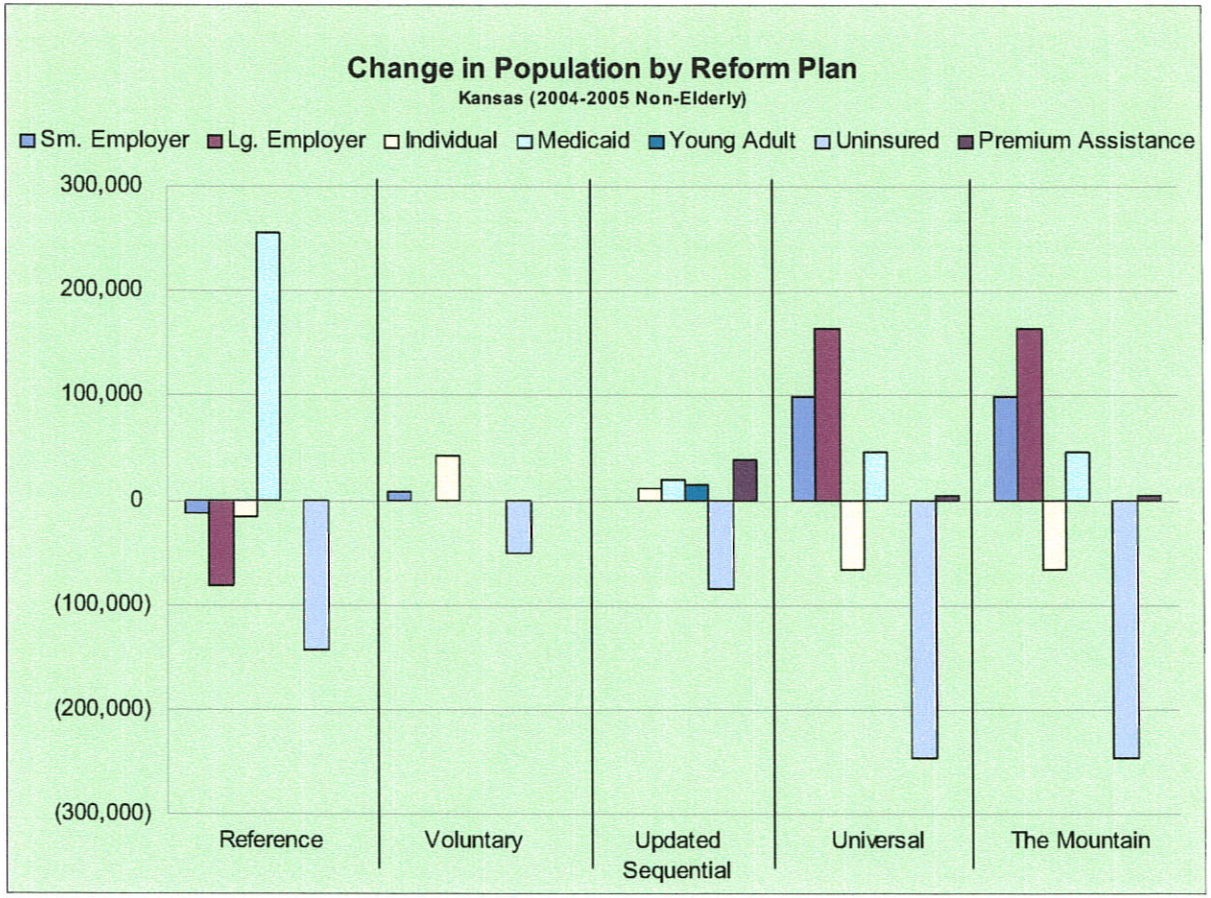
Summary of Total Dollars by Plan



Source: srHS HCRTC Model

DRAFT - SUBJECT TO CHANGE
ILLUSTRATIVE ONLY

Summary of Population Changes by Plan



Source: srHS HCRTC Model

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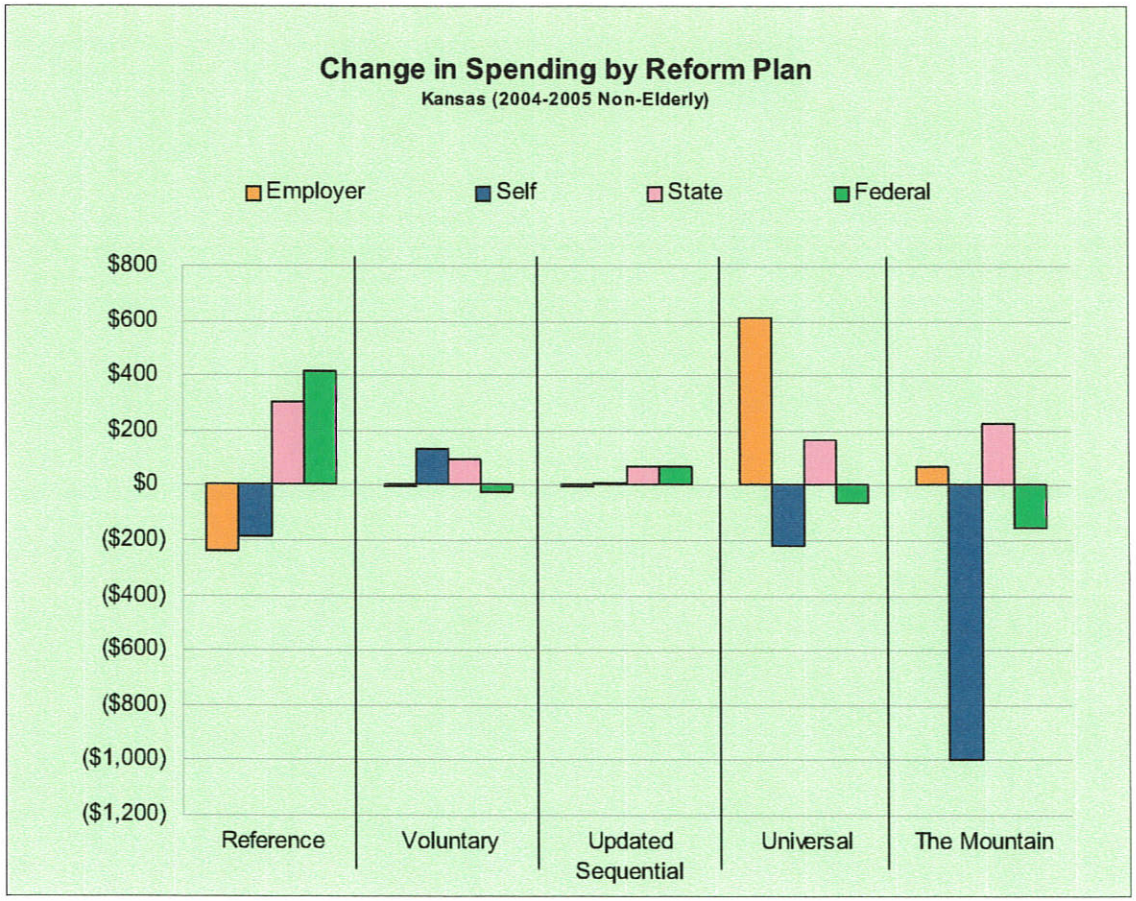
ILLUSTRATIVE ONLY

schramm raleigh HEALTH STRATEGY

2-10

Summary of Change in Spending by Plan



Source: srHS HCRTC Model

DRAFT - SUBJECT TO CHANGE
ILLUSTRATIVE ONLY

2-10